a seidlitz powder every three hours until the bowels moved at 2 a.m. on the third day, or about sixty hours after the operation. The first motion was soft and natural, with very little blood, mucus or pus. I continued the seidlitz powders, and the bowels moved again about 1 p.m. the same day. As long as she remained in the hospital, she was given saline purgatives to keep the bowels open, and when she left she was furnished with a large bottle of black draught with instructions to use it if required.

On account of the inflamed condition of the skin, and also because of the opening through the abdominal wall where the fistula had been, I was compelled to dress the wound every other day and use bismuth freely over the surface to keep it dry. I had two stitch abscesses, but fortunately they did not infect the deeper tissues. Indeed, in cases like this where one has to operate through tissues which cannot be rendered aseptic, the condition of the wound must be a constant source of great anxiety. The temperature reached 101°F. the first, third and fifth days after the operation, then came down and remained practically normal during her stay in the hospital. She left on July 22nd, eighteen days after the enterectomy, and was able to walk over one and a half miles to reach the railway station. I received a letter from her early this month (September) stating that she was quite well, and had had no difficulty since her return home.

Two important questions are now *sub judice* in reference to operations similar to the one I have here described. The first moot point is in reference to the use of rings or plates. A number of American surgeons have suggested that the technique could be improved by the use of decalcified bone plates, rubber plates, catgut rings, etc. I had the pleasure, last year, of seeing Dr. Dawbarn, of New York, demonstrate on the subject, his plan of using raw potato for plates. The consensus of opinion, however, seems to be returning to the original plan of simple suture. In some cases the rings have twisted, and thus become the causes of obstruction after the operation. Senn draws attention to the possibility that plates may be tied so tightly as to cause gangrene. R. F. Weir, in a paper on the subject, draws attention to the tendency of the opposed intestinal incisions to slip out beyond the rings or plates so that they have to be tucked back, often more than once. Dr. Abbe says "that the attempt to simplify the technique of lateral anastomosis by bone plates or other devices has not improved it." Dr. Bell, in a graphic description of gastro-enterostomy, published in *The Montreal Medical Journal*, in May, 1892, reports a case where the remains of the plates were found at the site of operation twenty days after, "the plate in the stomach still firm and scarcely altered in three-fourths of its periphery," and therefore a source of danger. The ease and safety with which suture without plates can be accomplished lead me to favour that plan.

The second question not yet decided is as to the preference between lateral anastomosis and end to end suture. The danger in each is cicatricial contraction of the opening, but, as in lateral anastomosis, the size of the opening is unlimited and perfect apposition is more easily obtained, it is, in my opinion, to be preferred.

EPITHELIOMA OF THE TONGUE.

BY DR. PRICE-BROWN, TORONTO.

On Nov. 17th, 1891, D. McL., aged 60, a temperate, hardworking man, referred by Dr. Nicol, presented himself for treatment. Five years previously, the centre of his tongue had been accidentally wounded by the root of a tree. Within a year a small growth commenced to form at the seat of injury. As this increased in size, it became painful, and was accompanied by profuse salivary discharge and painful deglutition. Prior to consulting Dr. Nicol, he had sought medical advice, with the result of partial excision of the growth. This was in the previous October, and from that time proliferation became more rapid.

Examination.—The patient was tall and gaunt, and had that peculiar hue of skin indicative of cancerous cachexia. Projecting from the upper surface of the tongue was a yellowish white substance, commencing a little over an inch from the tip, and extending backwards along the central raphe, about an inch and a quarter, The width in the centre was three-quarters of an inch, and the height above the surface about one-half inch. The mucous membrane of the tongue behind the growth was unusually hard, but the sublingual glands were unaffected.